FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0039115

Facility Name: WHEATON CARE CENTER

Address: 1325 MANCHESTER ROAD (Number) WHEATON (City) 60187 (Zip Code)

County: DUPAGE

Telephone Number: 630-668-2500 **Fax #** 630-668-0232

IDPA ID Number: 36-3905787-001

Date of Initial License for Current Owners: 09-01-1993

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) SEE ACCOUNTANT'S REPORT ATTACHED (Date)

(Print Name and Title) EDWARD SLACK, C.P.A.

(Firm Name & Address) FROST, RUTTENBERG & ROTHBLATT, P.C.
111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	82	Skilled (SNF)	82	30,012	1
2		Skilled Pediatric (SNF/PED)			2
3	41	Intermediate (ICF)	41	15,006	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	123	TOTALS	123	45,018	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	27,634	1,034	481	29,149	8
9	SNF/PED					9
10	ICF	13,611	509		14,120	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	41,245	1,543	481	43,269	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.11%

D. How many bed-hold days during this year were paid by Public Aid?
789 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 09/01/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 09/01/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 13 and days of care provided 481

Medicare Intermediary ADMINASTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	195,905	13,347	12,520	221,772		221,772	(8,774)	212,998			1
2	Food Purchase		152,094		152,094	(15,372)	136,722	3,996	140,718			2
3	Housekeeping	127,172	21,626		148,798		148,798	1,536	150,334			3
4	Laundry	68,053	18,071		86,124		86,124		86,124			4
5	Heat and Other Utilities			114,284	114,284		114,284	1,179	115,463			5
6	Maintenance	46,007		75,183	121,190		121,190	1,264	122,454			6
7	Other (specify):*							1,714	1,714			7
8	**TOTAL General Services**	437,137	205,138	201,987	844,262	(15,372)	828,890	915	829,805			8
	B. Health Care and Programs											
9	Medical Director			650	650		650		650			9
10	Nursing and Medical Records	1,227,025	29,733	31,694	1,288,452		1,288,452	4,381	1,292,833			10
10a	Therapy	24,681		8,726	33,407		33,407	(421)	32,986			10a
11	Activities	62,545	8,444	4,273	75,262		75,262	(454)	74,808			11
12	Social Services	129,095		2,299	131,394		131,394	545	131,939			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							5,152	5,152			15
16	**TOTAL Health Care and Programs**	1,443,346	38,177	47,642	1,529,165		1,529,165	9,204	1,538,369			16
	C. General Administration											
17	Administrative			196,560	196,560		196,560	24,305	220,865			17
18	Directors Fees											18
19	Professional Services			203,004	203,004		203,004	(169,256)	33,748			19
20	Dues, Fees, Subscriptions & Promotions			35,201	35,201		35,201	(16,484)	18,717			20
21	Clerical & General Office Expenses	93,435	10,248	112,216	215,899		215,899	(7,901)	207,998			21
22	Employee Benefits & Payroll Taxes			328,541	328,541	15,372	343,913	(29,600)	314,313			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,705	1,705		1,705	3,424	5,129			24
25	Other Admin. Staff Transportation			931	931		931	370	1,301			25
26	Insurance-Prop.Liab.Malpractice			56,300	56,300		56,300	785	57,085			26
27	Other (specify):*							31,960	31,960			27
28	**TOTAL General Administration**	93,435	10,248	934,458	1,038,141	15,372	1,053,513	(162,396)	891,117			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,973,918	253,563	1,184,087	3,411,568		3,411,568	(152,277)	3,259,291			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

WHEATON CARE CENTER
0039115
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS	15,372	
2	FOOD		15,372

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX		
19	PROFESSIONAL FEES		

To reclass cost of appealing real estate taxes

Facility Name & ID Number WHEATON CARE CENTER #0039115 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			48,745	48,745		48,745	7,545	56,290			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			26,641	26,641		26,641	(370)	26,271			32
33	Real Estate Taxes			49,362	49,362		49,362	1,596	50,958			33
34	Rent-Facility & Grounds			632,240	632,240		632,240	3,052	635,292			34
35	Rent-Equipment & Vehicles			10,722	10,722		10,722	2,522	13,244			35
36	Other (specify):*			648	648		648		648			36
37	**TOTAL Ownership**			768,358	768,358		768,358	14,345	782,703			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		46,680	11,205	57,885		57,885	(894)	56,991			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			67,527	67,527		67,527		67,527			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		46,680	78,732	125,412		125,412	(894)	124,518			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,973,918	300,243	2,031,177	4,305,338		4,305,338	(138,826)	4,166,512			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(697)	30		9
10	Interest and Other Investment Income	(9,301)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(54)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(16,002)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(49,000)	21		24
25	Fund Raising, Advertising and Promotional	(5,950)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(5,800)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(118)	20		28
29	Other-Attach Schedule	(2,908)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (89,830)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(48,996)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (48,996)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (138,826)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

WHEATON CARE CENTER

ID# 0039115

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$	6	1
2	Collection Expense	(2,253)	21	2
3	Bank Charges	(435)	21	3
4	Theft/Loss	(60)	21	4
5	C.O.P.E. Contribution	(160)	20	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
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81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	Total	(2,908)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			3,666	(4,490)		(7,951)						(8,774)	1
2	Food Purchase	(54)		(780)			4,830						3,996	2
3	Housekeeping			1,536									1,536	3
4	Laundry													4
5	Heat and Other Utilities			1,179									1,179	5
6	Maintenance			9,646	(8,404)		22						1,264	6
7	Other (specify):*			1,476			238						1,714	7
8	**TOTAL General Services**	(54)		16,723	(12,893)		(2,861)						915	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			18,604	(23,491)	13,710	4		(4,446)				4,381	10
10a	Therapy			3,594	(4,015)								(421)	10a
11	Activities			1,559	(2,013)								(454)	11
12	Social Services			1,374	(829)								545	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*			3,206		1,946							5,152	15
16	**TOTAL Health Care and Programs**			28,337	(30,348)	15,656	4		(4,446)				9,204	16
	C. General Administration													
17	Administrative			24,806	(136,385)	135,758	126						24,305	17
18	Directors Fees													18
19	Professional Services			6,531	(175,824)		37						(169,256)	19
20	Fees, Subscriptions & Promotions	(6,228)		959	(11,224)		9						(16,484)	20
21	Clerical & General Office Expenses	(73,550)		88,346	(22,822)		125						(7,901)	21
22	Employee Benefits & Payroll Taxes				(29,600)								(29,600)	22
23	Inservice Training & Education													23
24	Travel and Seminar			3,416			8						3,424	24
25	Other Admin. Staff Transportation			152			218						370	25
26	Insurance-Prop.Liab.Malpractice			785									785	26
27	Other (specify):*			13,052		18,908							31,960	27
28	**TOTAL General Administration**	(79,778)		138,047	(375,854)	154,666	523						(162,396)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(79,832)		183,107	(419,095)	170,322	(2,334)		(4,446)				(152,277)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WHEATON CARE CENTER # 0039115 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(697)		8,242									7,545	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(9,301)		8,924			7						(370)	32
33	Real Estate Taxes			1,596									1,596	33
34	Rent-Facility & Grounds			3,052									3,052	34
35	Rent-Equipment & Vehicles			2,511			11						2,522	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(9,998)		24,325			18						14,345	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(894)						(894)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**						(894)						(894)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(89,830)		207,432	(419,095)	170,322	(3,210)		(4,446)				(138,826)	45

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$	CARE CENTERS, INC.	100.00%	$ 3,666	$ 3,666	15
16	V	2	FOOD				(780)	(780)	16
17	V	3	HOUSEKEEPING				1,536	1,536	17
18	V	5	UTILITIES				1,179	1,179	18
19	V	6	REPAIRS AND MAINT.				9,646	9,646	19
20	V	7	EMP. BEN. - GEN. SERV.				1,476	1,476	20
21	V	10	NURSING				18,604	18,604	21
22	V	10A	THERAPY				3,594	3,594	22
23	V	11	ACTIVITIES				1,559	1,559	23
24	V	12	SOCIAL SERVICES				1,374	1,374	24
25	V	15	EMP. BEN. - HEALTHCARE				3,206	3,206	25
26	V	17	ADMINISTRATIVE				24,806	24,806	26
27	V	19	PROFESSIONAL FEES				6,531	6,531	27
28	V	20	DUES, SUBSCRIPTIONS				959	959	28
29	V	21	CLERICAL AND GENERAL				88,346	88,346	29
30	V	24	SEMINARS				3,416	3,416	30
31	V	25	AUTO EXPENSE				152	152	31
32	V	26	INSURANCE				785	785	32
33	V	27	EMP. BEN. - GEN. ADMIN.				13,052	13,052	33
34	V	30	DEPRECIATION				8,242	8,242	34
35	V	32	INTEREST	0			8,924	8,924	35
36	V	33	REAL ESTATE TAXES				1,596	1,596	36
37	V	34	BUILDING RENT - UNRELATED				3,052	3,052	37
38	V	35	EQUIPMENT RENTAL				2,511	2,511	38
39	Total			$			$ 207,432	$ * 207,432	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY CONS	$ 4,490	CARE CENTERS, INC.	100.00%	$ 0	$ (4,490)	15
16	V	19	ACCOUNTING	15,000			0	(15,000)	16
17	V	19	ANCIL ADMIN FEE	14,760			0	(14,760)	17
18	V	19	BOOKEEPING	25,092			0	(25,092)	18
19	V	19	DATA PROCESSING	4,428			0	(4,428)	19
20	V	19	LEGAL	11,224			0	(11,224)	20
21	V	19	MANAGEMENT FEE	103,320			0	(103,320)	21
22	V	19	PROFESSIONAL FEES	2,000			0	(2,000)	22
23	V	20	ADVERTISING	11,224			0	(11,224)	23
24	V						0		24
25	V						0		25
26	V	22	HOME OFFICE PAYROLL TAX	29,600			0	(29,600)	26
27	V	1	REBILL. PAYROLL DIETARY	0			0		27
28	V	3	REBILL. PAYROLL HSKPNG	0			0		28
29	V	6	REBILL. PAYROLL MAINT.	8,404			0	(8,404)	29
30	V	10	REBILL. PAYROLL NURSING	23,491			0	(23,491)	30
31	V	10A	REBILL. PAYROLL THPY CONS.	4,015			0	(4,015)	31
32	V	11	REBILL. PAYROLL ACTIVITIES	2,013			0	(2,013)	32
33	V	12	REBILL. PAYROLL SOC. SERV.	829			0	(829)	33
34	V	17	REBILL. PAYROLL ADMIN.	136,385			0	(136,385)	34
35	V	21	REBILL. PAYROLL CLERICAL	22,822			0	(22,822)	35
36	V								36
37	V								37
38	V								38
39	Total			$ 419,095			$ 0	$ * (419,095)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSING	$	CARE CENTERS, INC.	100.00%	$ 13,710	$ 13,710	15
16	V	15	EMP. BEN HEALTHCARE				1,946	1,946	16
17	V	17	ADMINISTRATIVE				135,758	135,758	17
18	V	27	EMP. BEN GEN. ADMIN.				18,908	18,908	18
19	V	0					0		19
20	V	0					0		20
21	V	0					0		21
22	V	0					0		22
23	V	0					0		23
24	V	0					0		24
25	V	0					0		25
26	V	0					0		26
27	V	0					0		27
28	V	0					0		28
29	V	0					0		29
30	V	0					0		30
31	V	0					0		31
32	V	0					0		32
33	V	0					0		33
34	V	0							34
35	V	0		0					35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 170,322	$ * 170,322	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$	CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	$ 2,495	$ 2,495	15
16	V	2	FOOD				4,830	4,830	16
17	V	6	MAINTENANCE				22	22	17
18	V	7	EMP. BEN. - GEN. SERV.				238	238	18
19	V	10	NURSING				4	4	19
20	V	17	ADMINISTRATIVE				126	126	20
21	V	19	PROFESSIONAL FEES				37	37	21
22	V	20	DUES, FEES, SUB.				9	9	22
23	V	21	CLERICAL & GENERAL				125	125	23
24	V	24	SEMINARS				8	8	24
25	V	25	TRAVEL				218	218	25
26	V	32	INTEREST				7	7	26
27	V	35	RENT - EQUIPMENT & VEHICLES				11	11	27
28	V	39	ANCILLARY ENTERAL SUPPLIES				163	163	28
29	V	1	DIETARY SUPP	10,446			0	(10,446)	29
30	V	39	ANCILLARY SUPP	1,057			0	(1,057)	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 11,503			$ 8,293	$ * (3,210)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	CLERICAL AND GENERAL	$	CARE CENTERS, INC.	100.00%	$ 0	$	15
16	V	27	EMP. BEN. - GEN. SERV. EMP. BEN.				0		16
17	V	0					0		17
18	V	0					0		18
19	V	0					0		19
20	V	0					0		20
21	V	0					0		21
22	V	0					0		22
23	V	0					0		23
24	V	0					0		24
25	V	0					0		25
26	V	0					0		26
27	V	0					0		27
28	V	0					0		28
29	V	0					0		29
30	V	0					0		30
31	V	0					0		31
32	V	0					0		32
33	V	0					0		33
34	V	0							34
35	V	0		0					35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	MEDICALSUPPLIES	$	XCEL MEDICAL SUPPLLY LLC	100.00%	$ 23,436	$ 23,436	15
16	V								16
17	V								17
18	V								18
19	V	10	MEDICALSUPPLIES	27,882				(27,882)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 27,882			$ 23,436	$ * (4,446)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INS.	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 76,637	$ 76,637	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INS.	76,637				(76,637)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 76,637			$ 76,637	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Owner	Administrative	21.95%	see attached	1.4	1.944%	Mgmt. Fee	$ 60,000	17-3	1
2	Norman Goldberg	Owner	Administrative	4.065%	see attached	1.43	2.860%	Alloc Salary	2,600	17-7	2
3	James Goodsite	Owner	Administrative	2.439%	see attached	1.43	2.860%	Alloc Salary	3,724	17-7	3
4	Mark Steinberg	Relative	Administrative	0%	see attached	1.43	2.860%	Alloc Salary	1,269	17-7	4
5	Gordon Brown	Owner	Administrative	.8133%	see attached	1.43	2.860%	Alloc Salary	1,820	17-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 69,413		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.**

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	PATIENT DAYS	1,512,231	32	$ 128,135	$ 128,055	43,269	$ 3,666	1
2	2	FOOD	PATIENT DAYS	1,512,231	32	(27,254)		43,269	(780)	2
3	3	HOUSEKEEPING	PATIENT DAYS	1,512,231	32	53,695	52,345	43,269	1,536	3
4	5	UTILITIES	PATIENT DAYS	1,512,231	32	41,192		43,269	1,179	4
5	6	REPAIRS AND MAINT.	PATIENT DAYS	1,512,231	32	337,107	220,731	43,269	9,646	5
6	7	EMP. BEN. - GEN. SERV.	PATIENT DAYS	1,512,231	32	51,593		43,269	1,476	6
7	10	NURSING	PATIENT DAYS	1,512,231	32	650,209	657,173	43,269	18,604	7
8	10A	THERAPY	PATIENT DAYS	1,512,231	32	125,600	125,524	43,269	3,594	8
9	11	ACTIVITIES	PATIENT DAYS	1,512,231	32	54,474	54,163	43,269	1,559	9
10	12	SOCIAL SERVICES	PATIENT DAYS	1,512,231	32	48,011	48,011	43,269	1,374	10
11	15	EMP. BEN. - HEALTHCARE	PATIENT DAYS	1,512,231	32	112,058		43,269	3,206	11
12	17	ADMINISTRATIVE	PATIENT DAYS	1,512,231	32	866,963	862,068	43,269	24,806	12
13	19	PROFESSIONAL FEES	PATIENT DAYS	1,512,231	32	228,254		43,269	6,531	13
14	20	DUES, SUBSCRIPTIONS	PATIENT DAYS	1,512,231	32	33,513		43,269	959	14
15	21	CLERICAL AND GENERAL	PATIENT DAYS	1,512,231	32	3,087,659	2,709,599	43,269	88,346	15
16	24	SEMINARS	PATIENT DAYS	1,512,231	32	119,372		43,269	3,416	16
17	25	AUTO EXPENSE	PATIENT DAYS	1,512,231	32	5,310		43,269	152	17
18	26	INSURANCE	PATIENT DAYS	1,512,231	32	27,429		43,269	785	18
19	27	EMP. BEN. - GEN. ADMIN.	PATIENT DAYS	1,512,231	32	456,163		43,269	13,052	19
20	30	DEPRECIATION	PATIENT DAYS	1,512,231	32	288,068		43,269	8,242	20
21	32	INTEREST	PATIENT DAYS	1,512,231	32	311,903		43,269	8,924	21
22	33	REAL ESTATE TAXES	PATIENT DAYS	1,512,231	32	55,780		43,269	1,596	22
23	34	BUILDING RENT - UNRELATE	PATIENT DAYS	1,512,231	32	106,673		43,269	3,052	23
24	35	EQUIPMENT RENTAL	PATIENT DAYS	1,512,231	32	87,772		43,269	2,511	24
25	TOTALS					$ 7,249,679	$ 4,857,669		$ 207,432	25

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	DIRECT ALLOCATION		9	307,262	298,696		13,710	1
2	15	EMP. BEN HEALTHCARE	DIRECT ALLOCATION		9	39,980			1,946	2
3	17	ADMINISTRATIVE	DIRECT ALLOCATION		24	1,436,904	1,436,850		135,758	3
4	27	EMP. BEN GEN. ADMIN.	DIRECT ALLOCATION		24	191,316			18,908	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,975,462	$ 1,735,546		$ 170,322	25

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	HEALTH SYSTEMS INC.	2,287,765	28	496,134	378,284	11,503	2,495	1
2	2	FOOD	HEALTH SYSTEMS INC.	2,287,765	28	960,501		11,503	4,830	2
3	6	MAINTENANCE	HEALTH SYSTEMS INC.	2,287,765	28	4,392		11,503	22	3
4	7	EMP. BEN. - GEN. SERV.	HEALTH SYSTEMS INC.	2,287,765	28	47,282		11,503	238	4
5	10	NURSING	HEALTH SYSTEMS INC.	2,287,765	28	700		11,503	4	5
6	17	ADMINISTRATIVE	HEALTH SYSTEMS INC.	2,287,765	28	25,000		11,503	126	6
7	19	PROFESSIONAL FEES	HEALTH SYSTEMS INC.	2,287,765	28	7,428		11,503	37	7
8	20	DUES, FEES, SUB.	HEALTH SYSTEMS INC.	2,287,765	28	1,836		11,503	9	8
9	21	CLERICAL & GENERAL	HEALTH SYSTEMS INC.	2,287,765	28	24,796		11,503	125	9
10	24	SEMINARS	HEALTH SYSTEMS INC.	2,287,765	28	1,526		11,503	8	10
11	25	TRAVEL	HEALTH SYSTEMS INC.	2,287,765	28	43,326		11,503	218	11
12	32	INTEREST	HEALTH SYSTEMS INC.	2,287,765	28	1,489		11,503	7	12
13	35	RENT - EQUIPMENT & VEHIC	HEALTH SYSTEMS INC.	2,287,765	28	2,182		11,503	11	13
14	39	ANCILLARY ENTERAL SUPPL	HEALTH SYSTEMS INC.	2,287,765	28	32,397		11,503	163	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,648,989	$ 378,284		$ 8,293	25

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	CLERICAL AND GENERAL	DIRECT ALLOCATION	100	1	31,075	31,075			1
2	27	EMP. BEN. - GEN. SERV. EMP.	DIRECT ALLOCATION	100	1	4,401				2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 35,476	$ 31,075		$	25

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: XCEL MEDICAL SUPPLY LLC
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-2330
Fax Number: (708)449-3236

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	MEDICALSUPPLIES	DIRECT ALLOCATION			$	$		$ 23,436	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 23,436	25

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLYEE BENEFITS GROUP, INC.
Street Address: 4101 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INS.	DIRECT ALLOCATION			$	$		$ 76,637	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 76,637	25

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Mortgage		X	Mortgage			$	$ 258,329			$ 24,378	1
2												2
3												3
4												4
5												5
	Working Capital											
6	DAIWA		X	Line of Credit				(115,619)			808	6
7			X	Insurance Financing							1,457	7
8												8
9	TOTAL Facility Related						$	$ 142,710			$ 26,643	9
	B. Non-Facility Related*											
10	Supplemental Schedule										8,931	10
11	Interest Income		X								(9,301)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (370)	14
15	TOTALS (line 9+line14)						$	$ 142,710			$ 26,273	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	CARE CENTERS, INC	X		ALLOCATION			$	$			$ 8,924	1
2	CCI HEALTH SYSTEMS	X		ALLOCATION							7	2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ 8,931	21

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	52,600	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	51,334	2
3. Under or (over) accrual (line 2 minus line 1).	$	(1,266)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	52,225	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	50,959	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	47,647	8
	1996	48,168	9
	1997	49,846	10
	1998	50,100	11
	1999	49,738	12

Accrual is 1999 taxes paid * 1.05. $49,738 * 1.05 = $52,225

Line 2 includes related party allocation of $1,596

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 30,000 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	CCI Allocation			$ 1,831	1
2					2
3	TOTALS			$ 1,831	3

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	41,331	1,206	20	2,067	861	15,195	9
10	Various			1994	104,965	3,380	20	5,250	1,870	35,051	10
11	Various			1995	16,968	596	20	849	253	4,894	11
12	CEILING TILE			1996	1,369	35	20	68	33	306	12
13	HUAL RENOV			1996	10,000	256	20	500	244	2,417	13
14	TOILER			1996	1,007	26	20	50	24	208	14
15	BLDG RENOV			1996	33,600	862	20	1,680	818	8,120	15
16	PAINTING & DECOR			1996	2,440	63	20	122	59	529	16
17	PLUMBING RENOV			1996	883	23	20	44	21	209	17
18	HVAC RENOV			1996	529	14	20	26	12	117	18
19	PLUMBING RENOV			1996	779	20	20	39	19	176	19
20	HVAC RENOV			1996	1,430	37	20	72	35	318	20
21	PAINTING & DECOR			1996	10,000	256	20	500	244	2,250	21
22	DRYWALL			1996	3,432	88	20	172	84	774	22
23	HVAC RENOV			1996	25,420	652	20	1,271	619	5,931	23
24											24
25	PAGE 12-1 REP TOTALS				40,795	1,085		1,353	268	5,434	25
26											26
27											27
28											28
29											29
30											30
31											31
32	PAGE 12D TOTALS				48,942	3,271		1,231	(2,040)	1,231	32
33	PAGE 12C TOTALS				52,859	1,347		2,647	1,300	4,702	33
34	PAGE 12B TOTALS				96,869	2,485		4,846	2,361	15,170	34
35	PAGE 12A TOTALS				107,116	2,747		5,357	2,610	21,920	35
36	TOTAL (lines 4 thru 35)				$ 600,734	$ 18,449		$ 28,144	$ 9,695	$ 124,952	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	HVAC RENOV			1996	9,421	242	20	471	229	2,120	9
10	CUBICLE CURTAINS			1996			20				10
11	PLUMBING RENOV			1996	512	13	20	26	13	113	11
12	DECORATING			1996	1,339	34	20	67	33	279	12
13	CABINETS			1996			20				13
14	FLOOR RENOV			1996	4,830	124	20	242	118	1,190	14
15	FLOORING			1996	2,905	74	20	145	71	592	15
16	BUILDING RENOV			1996	10,390	266	20	520	254	2,123	16
17	BLDG RENOV			1996	14,500	372	20	725	353	3,021	17
18	SIGNAL TRANSPORTER			1996	535	14	20	27	13	115	18
19	PLUMBING RENOV			1996	1,042	27	20	52	25	221	19
20	HVAC RENOV			1996	14,260	366	20	713	347	3,030	20
21	COVE BASE			1996	536	14	20	27	13	110	21
22	BOILER RENOV			1996	7,128	183	20	356	173	1,513	22
23	FIRE ALARM RENOV			1997	990	25	20	50	25	183	23
24	BUILDING RENOV			1997	1,800	46	20	90	44	360	24
25	LIGHTING			1997	1,622	42	20	81	39	324	25
26	HVAC RENOV			1997	886	23	20	44	21	136	26
27	CUBICLE CURTAINS			1997	14,743	378	20	737	359	2,948	27
28	FLOOR RENOV			1997	1,923	49	20	96	47	296	28
29	PLUMBING RENOV			1997	651	17	20	33	16	129	29
30	HVAC RENOV			1997	4,024	103	20	201	98	737	30
31	ELEVATOR RENOV			1997	5,489	141	20	274	133	982	31
32	SIGNAL DEVISE			1997	835	21	20	42	21	154	32
33	PAINTING & DECOR			1997	1,017	26	20	51	25	204	33
34	ALARM SYSTEM UPG			1997	588	15	20	29	14	94	34
35	FIRE ALARM RENOV			1997	5,150	132	20	258	126	946	35
36	TOTAL (lines 4 thru 35)				$ 107,116	$ 2,747		$ 5,357	$ 2,610	$ 21,920	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ELEVATOR RENOV			1997	3,700	95	20	185	90	725	9
10	TOILETS			1997	2,014	52	20	101	49	387	10
11	FLOORING RENOV			1997	880	23	20	44	21	139	11
12	FLOOR RENOV			1997	1,440	37	20	72	35	288	12
13	PARKING LOT RENOV			1997	4,600	118	20	230	112	805	13
14	PARKING LOT RENOV			1997	9,970	256	20	499	243	1,705	14
15	HVAC RENOV			1997	4,997	128	20	250	122	875	15
16	ELEVATOR RENOV			1997	7,278	187	20	364	177	1,183	16
17	HVAC RENOV			1997	3,000	77	20	150	73	500	17
18	HVAC RENOV			1997	4,000	103	20	200	97	683	18
19	ELECTRICAL RENOV			1997	3,640	93	20	182	89	637	19
20	ELEVATOR RENOV			1997	10,978	281	20	549	268	1,876	20
21	PLUMBING RENOV			1997	1,754	45	20	88	43	271	21
22	FLOOR RENOV			1997	832	21	20	42	21	165	22
23	PLUMBING RENOV			1997	540	14	20	27	13	86	23
24	HVAC RENOV			1997	3,798	97	20	190	93	681	24
25	ELECTRICAL RENOV			1997	551	14	20	28	14	100	25
26	SINK			1998	741	19	20	37	18	99	26
27	HVAC RENOV			1998	832	21	20	42	21	119	27
28	PLUMBING			1998	4,700	121	20	235	114	548	28
29	HVAC RENOVATION			1998	2,713	70	20	136	66	317	29
30	HVAC RENOVATION			1998	892	23	20	45	22	109	30
31	FIRE ALARM UPGRADES			1998	17,308	444	20	865	421	2,163	31
32	ICE MAKER			1998	2,465	63	20	123	60	318	32
33	MONITOR			1998	1,049	27	20	52	25	121	33
34	TRANSMITTER			1998	677	17	20	34	17	74	34
35	PAINTING			1998	1,520	39	20	76	37	196	35
36	TOTAL (lines 4 thru 35)				$ 96,869	$ 2,485		$ 4,846	$ 2,361	$ 15,170	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	PLUMBING			1998	1,300	33	20	65	32	135	9
10	PLUMBING			1998	776	20	20	39	19	101	10
11	TOILET BOWL			1998	659	17	20	33	16	69	11
12	ALARM SYSTEM			1998	1,032	26	20	52	26	117	12
13	GUARD SYSTEM			1998	5,875	151	20	294	143	613	13
14	TRANSMITTER			1998	535	14	20	27	13	56	14
15	FIRE DOOR			1998	1,090	28	20	55	27	119	15
16	FLOOR RENOV.			1998	1,550	40	20	78	38	221	16
17	GUARD SYSTEM			1998	5,875	151	20	294	143	662	17
18	HVAC RENOVATION			1998	1,184	30	20	59	29	133	18
19	DRYWALL			1998	4,100	105	20	205	100	461	19
20	DECORATING			1999	2,569	66	20	128	62	171	20
21	WALLPAPER			1999	2,700	69	20	135	66	191	21
22	PLUMBING RENOV			1999	716	18	20	36	18	72	22
23	WINDOW GLASS			1999	735	19	20	37	18	74	23
24	ELECTRIC RENOV			1999	1,245	32	20	62	30	124	24
25	ELECTRIC RENOV			1999	610	16	20	31	15	62	25
26	PAINTING			1999	999	26	20	50	24	75	26
27	SPRINKLER SYS			1999	3,250	83	20	163	80	312	27
28	SEWER RENOV			1999	710	18	20	36	18	48	28
29	PLUMBING			1999	1,807	46	20	90	44	113	29
30	FALL CLEANUP			1999	1,492	38	20	75	37	88	30
31	PAINTING			1999	1,165	30	20	58	28	63	31
32	PLUMBING RENOV			1999	750	19	20	38	19	57	32
33	PLUMBING RENOV			1999	950	24	20	48	24	80	33
34	PLUMBING RENOV			1999	1,588	41	20	79	38	105	34
35	CARPETING			2000	7,597	187	20	380	193	380	35
36	TOTAL (lines 4 thru 35)				$ 52,859	$ 1,347		$ 2,647	$ 1,300	$ 4,702	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	HVAC			2000	637	6	20	13	7	13	9
10	HOT WATER PUMP			2000	862	8	20	18	10	18	10
11	A/C RENOV			2000	1,286	18	20	37	19	37	11
12	TREE REMOVAL			2000	4,850	67	20	142	75	142	12
13	DRAPES			2000	1,838	14	20	31	17	31	13
14	REMOVE WATER SOFTNER			2000	1,500	33	20	69	36	69	14
15	CARPETING			2000	4,682	35	20	78	43	78	15
16	A/C RENOV/PLUMBING			2000	756	2	20	6	4	6	16
17	A/C RENOV/PLUMBING			2000	599	9	20	20	11	20	17
18	A/C RENOV/PLUMBING			2000	2,025	11	20	25	14	25	18
19	SHINGLES			2000	2,200	7	20	18	11	18	19
20	A/C RENOV/PLUMBING			2000	777	4	20	10	6	10	20
21	MOTOR RENOV			2000	672	5	20	11	6	11	21
22	WATER RENOV			2000	1,248	9	20	21	12	21	22
23	A/C RENOV			2000	998	8	20	17	9	17	23
24	PIPING RENOV			2000	2,945	22	20	49	27	49	24
25	A/C RENOV/PLUMBING			2000	3,346	18	20	42	24	42	25
26	HOT WATER PUMP			2000	1,032	10	20	22	12	22	26
27	A/C RENOV			2000	1,877	22	20	47	25	47	27
28	DOORS			2000	544	109	20	45	(64)	45	28
29	WATER HEATER RENOVATION			2000	5,985	1,197	20	349	(848)	349	29
30	WATERHEATER RENOVATION			2000	665	133	20	34	(99)	34	30
31	FAUCETS			2000	818	164	20	14	(150)	14	31
32	NURSE CALL SYSTEM			2000	6,800	1,360	20	113	(1,247)	113	32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 48,942	$ 3,271		$ 1,231	$ (2,040)	$ 1,231	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
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21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			CCI Alloc	1996	$ 32,408	$ 831	35	$ 926	$ 95	$ 3,781	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	CCI ALLOCATION			2000	39	1	20	2	1	2	9
10	CCI ALLOCATION			1999	580	15	20	29	14	55	10
11	CCI ALLOCATION			1998	239	6	20	12	6	32	11
12	CCI ALLOCATION			1997	3,399	78	20	187	109	908	12
13	CCI ALLOCATION			1996	3,736	49	20	180	131	617	13
14	CCI ALLOCATION			1994		11	20		(11)		14
15	CCI ALLOCATION			1993		3	20		(3)		15
16	CCI ALLOCATION			1997	394	91	20	17	(74)	39	16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 40,795	$ 1,085		$ 1,353	$ 268	$ 5,434	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 247,782	$ 29,339	$ 24,141	$ (5,198)		$ 98,743	37
38	Current Year Purchases	30,170	5,864	1,630	(4,234)		1,585	38
39	Fully Depreciated Assets	7,875					7,875	39
40								40
41	TOTALS	$ 285,827	$ 35,203	$ 25,771	$ (9,432)		$ 108,203	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	CCI Allocation			$ 15,394	$ 3,335	$ 2,375	$ (960)	5	$ 5,329	42
43										43
44										44
45										45
46	TOTALS			$ 15,394	$ 3,335	$ 2,375	$ (960)		$ 5,329	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 903,786	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 56,987	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 56,290	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (697)	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 238,484	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

WHEATON CARE CENTER
0039115
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
LINE 28: PRIOR YEARS					
WHEATON CARE CENTER	220,298	25,783	21,170	(4,613)	86,002
CARE CENTERS, INC	27,484	3,556	2,971	(585)	12,741
TOTALS	247,782	29,339	24,141	(5,198)	98,743
LINE 29: CURRENT YEAR					
WHEATON CARE CENTER	28,622	5,598	1,594	(4,004)	1,549
CARE CENTERS, INC	1,548	266	36	(230)	36
TOTALS	30,170	5,864	1,630	(4,234)	1,585
LINE 30: FULLY DEPRECIATED					
WHEATON CARE CENTER	7,875				7,875
CARE CENTERS, INC					
TOTALS	7,875				7,875
TOTALS (Should Tie to Totals on Page 13)					
WHEATON CARE CENTER	256,795	31,381	22,764	(8,617)	95,426
CARE CENTERS, INC	29,032	3,822	3,007	(815)	12,777
TOTALS	285,827	35,203	25,771	(9,432)	108,203

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NWOS GENERAL PARTNERSHIP
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		123		$ 632,240			3
4	Additions							4
5	ALLOC FROM CCI				3,052			5
6								6
7	TOTAL		123		$ 635,292 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning 09/01/93
    Ending 08/30/08

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$ 643,000
13.	/2002	$ 654,000
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 5,744 Description: See Attached
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	Van	$ 625.00	$ 7,500	17
18					18
19					19
20					20
21	TOTAL		$ 625.00	$ 7,500	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 4,021	$		$ 4,021	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			571			571	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			6,613			6,613	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				23,411		23,411	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): **SEE SUPPLEMENTAL SCHEDULE**						23,269		23,269	13
14	TOTAL			$		$ 11,205	$ 46,680		$ 57,885	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1	Medical Supplies	19,869
2	Complex Medical Equip	325
3	Radiology	293
4	Laboratory	314
5	Respiratory Supplies	966
6	Enteral Supplies	1,502
7		
8		
9		
10		
		23,269

	Outside Therapies (Column 5 - Other)	Amount
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 4,999	$	1
2	Cash-Patient Deposits	32,971		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	755,088		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	101,854		6
7	Other Prepaid Expenses	3,142		7
8	Accounts Receivable (owners or related parties)	(7,863)		8
9	Other(specify): See supplemental schedule	40,414		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 930,605	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cos	514,653		15
16	Equipment, at Historical Cost	302,084		16
17	Accumulated Depreciation (book methods)	(266,920)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	309,301		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 859,118	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,789,723	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 249,854	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	32,968		28
29	Short-Term Notes Payable	(115,619)		29
30	Accrued Salaries Payable	145,419		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,946		31
32	Accrued Real Estate Taxes(Sch.IX-B)	52,224		32
33	Accrued Interest Payable			33
34	Deferred Compensation	3,955		34
35	Federal and State Income Taxes	14,354		35
	Other Current Liabilities(specify):			
36	See supplemental schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 393,101	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	258,329		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 258,329	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 651,430	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,138,293	$ #REF!	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,789,723	$ #REF!	48

*(See instructions.)

Facility Name & ID Number WHEATON CARE CENTER **#** 0039115 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES **As of** 12/31/00

OTHER CURRENT ASSETS:	Amount	Amount
Real Estate Tax Escrow	36,460	
Due from Employees	3,954	
	40,414	

OTHER CURRENT LIABILITIES:	Amount	Amount

OTHER NON CURRENT ASSETS:		
Financing Fees (Net of Accum Amort)	1,801	
Option Deposit	307,500	
	309,301	

OTHER NON CURRENT LIABILITIES:	Amount	Amount

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,049,897	1
2	Restatements (describe):		2
3	Schedule attached		3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,049,897	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	387,596	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(299,200)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 88,396	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,138,293	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number	WHEATON CARE CENTER	#	0039115	Report Period Beginning:	01/01/00	Ending:	12/31/00

Balance per General Ledger		1,049,897
Adjustments:		
		-
		-
		-
Total adjustments		-
Balance - Beginning of Year		1,049,897
Equity(Deficit) from Page 17 Col 1		1,138,293
Related Party		
Equity(Deficit)	0	
Income	0	
		-
Combined Equity - End of Year		1,138,293

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,650,480	1
2	Discounts and Allowances for all Levels	(83,200)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,567,280	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	57,740	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 57,740	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	16,125	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,008	19
20	Radiology and X-Ray	288	20
21	Other Medical Services	37,192	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 58,613	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	9,301	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 9,301	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,692,934	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	844,262	31
32	Health Care	1,529,165	32
33	General Administration	1,038,141	33
	B. Capital Expense		
34	Ownership	768,358	34
	C. Ancillary Expense		
35	Special Cost Centers	57,885	35
36	Provider Participation Fee	67,527	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,305,338	40
41	**Income before Income Taxes (line 30 minus line 40)****	387,596	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 387,596	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number **WHEATON CARE CENTER** **# 0039115** **Report Period Beginning:** **01/01/00** **Ending:** **12/31/00**

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/00

	DESCRIPTION	AMOUNT
1	Vending Commissions	
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
	TOTALS	

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,688	1,842	$ 48,911	$ 26.55	1
2	Assistant Director of Nursing	1,994	2,268	48,708	21.48	2
3	Registered Nurses	13,995	15,346	310,194	20.21	3
4	Licensed Practical Nurses	11,886	13,515	253,226	18.74	4
5	Nurse Aides & Orderlies	47,717	52,476	550,868	10.50	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,657	2,030	24,681	12.16	8
9	Activity Director	1,992	2,104	23,891	11.36	9
10	Activity Assistants	4,250	4,662	38,653	8.29	10
11	Social Service Workers	9,936	10,489	129,095	12.31	11
12	Dietician					12
13	Food Service Supervisor	1,680	1,808	21,480	11.88	13
14	Head Cook	6,109	6,773	70,962	10.48	14
15	Cook Helpers/Assistants	11,445	12,615	103,463	8.20	15
16	Dishwashers					16
17	Maintenance Workers	3,777	4,021	46,007	11.44	17
18	Housekeepers	14,740	15,855	127,172	8.02	18
19	Laundry	8,366	9,022	68,053	7.54	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,319	9,107	93,435	10.26	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,232	1,350	15,118	11.20	31
32	Other Health Care(specify)					32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	149,783	165,283	$ 1,973,917 *	$ 11.94	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 12,520	1-3	35
36	Medical Director	5	650	9-3	36
37	Medical Records Consultant	Monthly	4,032	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,170	10-3	39
40	Physical Therapy Consultant	68	3,378	10a-3	40
41	Occupational Therapy Consultant	15	725	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	12	608	10a-3	43
44	Activity Consultant	57	2,260	11-3	44
45	Social Service Consultant	Monthly	1,470	12-3	45
46	Other(specify)				46
47	CCI Consultants (see attached)		30,348		47
48					48
49	TOTAL (lines 35 - 48)	157	$ 60,161		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$ 0		53

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
		$	$
0	0	$ 0	$ #DIV/0!

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Administrators paid through CCI			$
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
Administrator Salary - CCI	$ 85,296
Asst. Administrator Salary - CCI	51,089
Chris Wayer - Management Fee	175
Eric Rothner - Management Fee	60,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 196,560
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Neal Gerber (see attached)	Legal Services	$ 10,458
Care Centers, Inc.	Legal Services	11,224
Care Centers, Inc.	Accounting	15,000
Frost, Ruttenberg & Rothblatt	Accounting	10,365
Care Centers, Inc.	Data Processing	4,428
Alpha Data Systems	Data Processing	3,379
Threshold	Data Processing	190
Integrated Inventory Tech	Data Processing	920
MaxxSource	Data Processing	1,000
Care Centers, Inc.	Home Office Expense	103,320
Care Centers, Inc.	Ancillary Admin Svcs.	14,760
See Attached	Other Professional Services	27,960
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 203,004

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 60,637
Unemployment Compensation Insurance	24,200
FICA Taxes	149,152
Employee Health Insurance	
Employee Meals	15,372
Illinois Municipal Retirement Fund (IMRF)*	
Health Insurance	45,435
Pension Expense	9,640
Other Employee Benefits	9,877
TOTAL (agree to Schedule V, line 22, col.8)	$ 314,313

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	8,575
Health Care Worker Background Check	
(Indicate # of checks performed 44)	528
Licenses & Fees	1,190
Subscriptions	7,256
Advertising & Promotion	5,950
Yellow Pages	118
CCI Allocation	959
CC Health Systems Allocation	9
Less: Public Relations Expense	( )
Non-allowable advertising	(5,950)
Yellow page advertising	(118)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,717

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,705
CCI Allocation	3,416
CC Health Systems Allocation	8
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,129

**See instructions.

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number WHEATON CARE CENTER # 0039115 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **$3332 - IL Council on LTC**

(3) Did the nursing home make political contributions or payments to a politica action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,496** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. $ **67,527**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ **15,372** Has any meal income been offset against related costs? **NO** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **NONE**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Date: **07/17/2000**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to b entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "A Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu ba after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use Fi Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been seale you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can g to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw